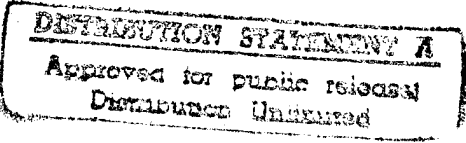


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6. AUTHOR(S) D. Bechtold			
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13. ABSTRACT (Maximum 200 Words) This Directive reissues DoD Directive 6025.13 dated November 17, 1988, and replaces DoD Directives 6025.6 and 6025.11 and DoD Instruction 6025.9. It revises the Department's clinical quality assurance program in recognition of medical readiness and managed healthcare policies promulgated by the Assistant Secretary of Defense for Health Affairs (ASD(HA)); establishes clinical monitoring and improvement practices for healthcare services whether provided in the direct care system, under preferred provider agreements, or other means established in support of managed care; issues CQMP guidance for the Military Services before and in anticipation of full implementation of managed healthcare initiatives; specifies criteria, including medical readiness certification, by which the Military Services evaluate healthcare services.			
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Department of Defense **DIRECTIVE**

July 20, 1995
NUMBER 6025.13

ASD(HA)

SUBJECT: Clinical Quality Management Program (CQMP) in the Military Health Services System (MHSS)

- References:
- (a) DoD Directive 6025.13, "DoD Medical Quality Assurance," November 17, 1988 (hereby canceled)
 - (b) DoD Directive 6025.11, "DoD Health Care Provider Credentials Review and Clinical Privileging," May 20, 1988 (hereby canceled)
 - (c) DoD Instruction 6025.9, "Patients' Bill of Rights and Responsibilities," August 20, 1987 (hereby canceled)
 - (d) DoD Directive 6025.6, "Licensure of DoD Health Care Personnel," June 6, 1988 (hereby canceled)
 - (e) through (q), see enclosure 1

A. REISSUANCE AND PURPOSE

This Directive:

1. Reissues reference (a) and replaces references (b) through (d).
2. Revises the Department's clinical quality assurance program in recognition of medical readiness and managed healthcare policies promulgated by the Assistant Secretary of Defense for Health Affairs (ASD(HA)).
3. Establishes clinical monitoring and improvement practices for healthcare services whether provided in the direct care system, under preferred provider agreements, or other means established in support of managed care.
4. Issues CQMP guidance for the Military Services before and in anticipation of full implementation of managed healthcare initiatives.
5. Specifies criteria, including medical readiness certification, by which the Military Services evaluate healthcare services.

B. APPLICABILITY AND SCOPE

1. This Directive applies to:
 - a. The Office of the Secretary of Defense, the Military Departments, the Chairman of the Joint Chiefs of Staff, the Unified Combatant Commands, the Inspector General of the

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Department of Defense, the Uniformed Services University of the Health Sciences, the Defense Agencies, and the DoD Field Activities (hereafter referred to collectively as "the DoD Components"). The term "Military Services," as used herein, refers to the Army, the Navy, the Air Force, and the Marine Corps.

b. DoD healthcare practitioners who are involved in the delivery of healthcare services to eligible beneficiaries.

c. DoD medical and dental treatment facilities (MTF/DTFs).

d. Groups of civilian preferred providers, under managed care support contracts to the Department of Defense, in health services regions throughout the MHSS.

e. DoD personnel who prepare and evaluate contract specifications and who select, procure, and administer networks of civilian preferred providers to deliver healthcare to eligible beneficiaries.

2. This Directive describes:

a. The required elements of the MHSS CQMP.

b. Criteria that the Military Services shall use in the selection and procurement of healthcare practitioners and preferred provider networks.

C. DEFINITIONS

Terms used in this Directive are defined in enclosure 2.

D. POLICY

It is DoD policy to:

1. Ensure medical readiness, develop and promulgate standard CQMP requirements, integrate processes necessary to evaluate healthcare services, and improve outcomes for all DoD beneficiaries. Key CQMP elements shall include:

a. Medical Readiness Training Certification. The Services shall require Active and Reserve component healthcare providers to earn medical readiness certification that documents preparation for assignments during military operations. The certification shall be reviewed and verified by the Medical Commander every 12 months. Noncompliance with the certification requirement may be the basis for adverse personnel actions, such as withholding of special pays, promotions, awards, or actions under the Uniform Code of Military Justice (reference (e)).

b. Accreditation

(1) All fixed hospitals and free-standing ambulatory clinics, including those providing care to DoD beneficiaries under various managed care support contracts, shall maintain accreditation by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), under the "Accreditation Manual for Hospitals" (reference (f)) or the "Ambulatory Health Care Standards Manual" (reference (g)), or as a component of a network system approved by the Service under the "Accreditation Manual for Health Care Networks" (reference (h)), or through an accreditation source approved by the ASD(HA).

(2) Operational ambulatory clinics (those treating active duty personnel only) are exempt from the accreditation requirement. Each Military Service shall establish and implement comparable quality of care oversight mechanisms for those operational clinics under its cognizance.

(3) Hospital-sponsored alcoholism and drug dependence programs shall maintain accreditation under the standards contained in reference (f). All other Service-sponsored, free-standing alcoholism and drug dependence programs shall maintain accreditation through the "Accreditation Manual for Mental Health, Chemical Dependency, and Mental Retardation/Developmental Disabilities Services" (reference (i)) or the Commission on Accreditation of Rehabilitation Facilities (CARF) in the "Standards Manual for Organizations Serving People With Disabilities" (reference (j)).

(4) All preferred provider networks shall maintain accreditation either through the JCAHO in reference (h) or through the National Committee on Quality Assurance (NCQA) in the "NCQA Standards for Accreditation and Review Guidelines" (reference (k)).

(5) All MTFs and networks listed in subparagraphs D.1.b.(1), (3), and (4), above, shall attain and maintain accreditation within 3 years of the issuance of this Directive. The ASD(HA) shall consider accreditation waivers on a case-by-case basis. Waiver requests shall specify patient volume statistics, provider specialty mix, ongoing performance, and alternate oversight mechanisms.

(6) Accreditation guidance is found in references (f) through (k) and will not be duplicated in this Directive. When appropriate, the ASD(HA) shall direct policy and procedures that exceed the standards of accrediting bodies and issue implementing instructions.

c. Preselection Criteria for Healthcare Practitioners. Certain credentials shall be collected and verified before the selection, employment, or contract of healthcare practitioners, as defined in enclosure 3. Staff appointments and clinical privileges shall be granted to healthcare providers only after all pre-selection criteria required in enclosure 3 have been verified through the primary source. Substantial errors of fact involving documents discovered before or after appointment can be the basis for non-selection or, after appointment, adverse action including separation and termination.

d. Credentials and Clinical Privileges

(1) Licensure. Healthcare practitioners shall possess and maintain a current, valid, and unrestricted license or other authorizing document, as defined in enclosure 2, in accordance with the issuing authority, before practicing within the defined scope of practice for like specialties. Healthcare practitioners who do not possess a license or other authorizing document may practice only under a written plan of supervision with a licensed person of the same or a similar discipline. The Military Services may exempt any of the following practitioner groups from the requirements of this subparagraph until October 1, 1998: audiologists, clinical dietitians, occupational therapists, social workers, and speech pathologists.

(2) Waivers. Authority to waive the license requirement is vested with the ASD(HA) and shall be used only to address extraordinary circumstances. A waiver shall require compelling documentation of career potential and competent performance on the part of the involved individual. Such documentation shall be endorsed by the Surgeon General of the applicable Military Department.

(3) Clinical Privileges and Appointment to the Medical and/or Dental Staff

(a) The Military Services and preferred provider networks shall designate the privileging authorities for healthcare providers who are responsible for making decisions to diagnose, alter, or terminate a regimen of healthcare.

(b) Before providing care, healthcare providers shall be subject to review of licensure, relevant training and/or experience, current competence, and health status and shall be granted delineated clinical privileges with or without a medical staff appointment. Re-appointment shall occur at least every 2 years.

(4) DoD Inter-Facility Credentials Transfer and Privileging. The Military Services shall recognize mutually established inter-facility transfer and privileging mechanisms when DoD healthcare providers are temporarily assigned to MTF/DTFs for clinical practice.

e. National Practitioner Data Bank (NPDB). The NPDB shall be queried for physicians and dentists before the appointment and reappointment to the medical or dental staff. Reportable acts of misconduct for DoD healthcare practitioners are listed in enclosure 4. Reports shall be made to the NPDB in cases of adverse actions and malpractice claims payment in accordance with the policy and procedures outlined in DoD Directives 5154.24 and 6025.14 (references (l) and (m) and DoD Instruction 6025.15 (reference (n))).

f. Quality Management Contract. The Department of Defense shall continue to support an independent, impartial evaluation of selected aspects of healthcare performance through centralized quality management contracts. Multidisciplinary panels of military and civilian consultants shall develop criteria for clinical practice guidelines, clinical outcome measures, special studies, and education initiatives. Focused studies shall periodically review statistically significant samples of cases related to selected aspects of care as directed by the ASD(HA).

This type of review shall serve to eliminate local or Service bias, heighten awareness of key process characteristics, and allow for a better understanding of best clinical practice.

g. Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) Administration. Designated provider networks operating under DoD-managed healthcare contracts and other CHAMPUS-authorized civilian providers shall comply with requirements of DoD 6010.8-R (reference (o)). All requirements of this Directive applicable to such networks and providers shall be incorporated into reference (o), and shall become effective upon such incorporation.

h. Annual Summary. Each Service shall submit a summary of the MHSS CQMPs under its cognizance to the ASD(HA) no later than 90 days after the end of each calendar year. The summary shall focus on process and outcome improvements that demonstrably achieve desired clinical outcomes, optimize resource economies, enhance service, and other matters related to medical readiness and the delivery of quality healthcare as requested by the ASD(HA).

E. RESPONSIBILITIES

1. The Assistant Secretary of Defense for Health Affairs, under the Under Secretary of Defense for Personnel and Readiness, shall:

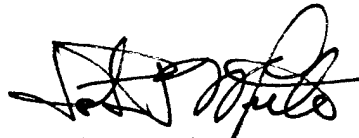
- a. Issue Instructions, as necessary, to implement the policies of this Directive.
- b. Monitor the implementation of this Directive to ensure consistent application across the MHSS.
- c. Ensure all preferred provider healthcare contracts reflect the policies set forth in this Directive.
- d. Exercise authority to grant waivers to this Directive in exceptional circumstances.

2. The Secretaries of the Military Departments shall:

- a. Ensure compliance with this Directive.
- b. Establish the key elements of a CQMP for those operational air, ground, and fleet clinics that are not accredited by a nationally recognized body such as the JCAHO.
- c. Recommend changes in the CQMP to the Secretary of Defense through the ASD(HA).
- d. Ensure that the Surgeons General of the Military Departments comply with this Directive, including the requirement for Medical Readiness Certification and preferred provider support contracts.

F. EFFECTIVE DATE

This Directive is effective immediately.

A handwritten signature in black ink, appearing to read 'John P. White', with a stylized, cursive script.

John P. White
Deputy Secretary of Defense

Enclosures - 4

1. References
2. Definitions
3. Preselection Criteria for Healthcare Practitioners
4. Reportable Actions of Misconduct for DoD Healthcare Practitioners

REFERENCES, continued

- (c) Sections 801 through 940 of title 10, United States Code, "Uniform Code of Military Justice"
- (f) Joint Commission on Accreditation of Healthcare Organizations, "Accreditation Manual for Hospitals," Volumes I & II, current editions¹
- (g) Joint Commission on Accreditation of Healthcare Organizations, "Ambulatory Healthcare Standards Manual," Volumes I & II, current editions²
- (h) Joint Commission on Accreditation of Healthcare Organizations, "Accreditation Manual for Health Care Networks," current edition³
- (i) Joint Commission on Accreditation of Healthcare Organizations, "Accreditation Manual for Mental Health, Chemical Dependency, and Mental Retardation/Developmental Disabilities Services," current edition⁴
- (j) Commission on Accreditation of Rehabilitation Facilities (CARF), "Standards Manual for Organizations Serving People With Disabilities," current edition⁵
- (k) National Committee for Quality Assurance, "NCQA Standards for Accreditation and Review Guidelines," current edition⁶
- (l) DoD Directive 5154.24, "Armed Forces Institute of Pathology (AFIP)," April 10, 1992
- (m) DoD Directive 6025.14, "Department of Defense Participation in the National Practitioner Data Bank (NPDB)," November 1, 1990
- (n) DoD Instruction 6025.15, "Implementation of Department of Defense Participation in the National Practitioner Data Bank (NPDB)," November 9, 1992
- (o) DoD 6010.8-R, "Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)," July 1991, authorized by DoD Instruction 6010.8, October 24, 1984
- (p) DoD Instruction 1402.5, "Criminal History Background Checks On Individuals in Child Care Services," January 19, 1993
- (q) Sections 801 through 977 of title 21, United States Code, "The Comprehensive Drug Abuse Prevention and Control Act of 1970"

¹through⁴ Available from the Joint Commission on Accreditation of Healthcare Organizations, One Renaissance Boulevard, Oakbrook Terrace, Illinois 60181

⁵Available from the Commission on Accreditation of Rehabilitation Facilities, 101 North Wilmot Road, Suite 500, Tucson, Arizona 85711

⁶Available from the National Committee for Quality Assurance, 1350 New York Avenue, NW, Washington, DC 20005

DEFINITIONS

1. Adverse Privileging Action. The denial, suspension, or revocation of clinical privileges based upon misconduct, professional impairment, or lack of professional competence. The termination of professional staff appointment based upon conduct incompatible with continued professional staff membership may also result in an adverse privileging action.
2. Clinical Practice Guidelines. Systematically developed statements to assist practitioner and patient decisions about appropriate healthcare for specific clinical circumstances.
3. Clinical Privileging. The process whereby a healthcare provider is granted the permission and responsibility to provide specified or delineated healthcare within the scope of his or her license, certification, or registration. Clinical privileges define the scope and limits of practice for individual providers and are based on the capability of the healthcare facility, licensure, relevant training and experience, current competence, health status, judgment, and peer and department head recommendations.
4. Clinical Quality Management Program (COMP). The program that emphasizes leadership commitment to quality performance, regardless of the practice site (including operational platforms), a supportive organizational culture, and the evaluation of the effectiveness of clinical performance improvement activities. These activities include structured processes that design, measure, assess, and improve the healthcare status of beneficiaries and the quality of all healthcare services provided to them.
5. Credentials. The documents that constitute evidence of training, licensure, experience, health status, and current competence of a healthcare practitioner.
6. Credentials Review. The credentials screening process conducted on healthcare practitioners before selection for military service, employment, and procurement. The credentials review process is also conducted on healthcare providers before medical staff appointment and granting of clinical privileges, and is repeated at the time of reappointment and renewal of privileges.
7. Credentials, Verified. Documents for which confirmation of authenticity has been obtained from the primary (issuing) source by the Military Service or a representative of the Military Service. Confirmation, independent of the practitioner, is a key criterion. Once verified, confirmation of authenticity with the primary source need not be repeated during subsequent credentials review.
8. Current Competence. The state of having adequate ability to perform the functions of a practitioner in a particular discipline as measured by meeting the following conditions:
 - a. Authorized to practice a specified scope of care under a written plan of supervision at any time within the past 2 years; or, completed formal graduate professional education in a specified clinical specialty at any time within the past 2 years; or, privileged to practice a specified scope of care at any time within the past 2 years;

b. Actively pursued the practice of his or her discipline within the past 2 years by having encountered a sufficient number of clinical cases to represent a broad spectrum of the privileges requested; and,

c. Satisfactorily practiced the discipline as determined by the results of professional staff monitoring and evaluation of the quality and appropriateness of patient care.

9. Healthcare Practitioner. Any physician, dentist, or healthcare practitioner of one of the professions whose members are required to possess a professional license or other authorization, as prescribed in this Directive. These include DoD healthcare personnel who are physicians, dentists, registered nurses, practical nurses, physical therapists, podiatrists, optometrists, clinical dietitians, social workers, clinical pharmacists, clinical psychologists, occupational therapists, audiologists, speech pathologists, physician assistants, or any other person providing direct patient care as may be designated by the ASD(HA).

10. Healthcare Provider. Military (Active or Reserve component) and civilian personnel (Civil Service and providers working under contractual or similar arrangement) granted privileges to diagnose, initiate, alter, or terminate healthcare treatment regimens within the scope of his or her license, certification, or registration. This category includes physicians, dentists, nurse practitioners, nurse anesthetists, nurse midwives, physical therapists, podiatrists, optometrists, clinical dietitians, social workers, clinical pharmacists, clinical psychologists, occupational therapists, audiologists, speech pathologists, physicians assistants, or any other person providing direct patient care as may be designated by the ASD(HA).

11. License. A grant of permission by an official agency of a State, the District of Columbia, a Commonwealth, territory, or possession of the United States to provide healthcare within the scope of practice for a discipline.

a. Current. Active, not revoked, suspended, or lapsed in registration.

b. Valid. The issuing authority accepts, investigates, and acts upon quality assurance information, such as practitioner professional performance, conduct, and ethics of practice, regardless of the practitioner's military status or residency.

c. Unrestricted. Not subject to limitations on the scope of practice ordinarily granted all other applicants for similar specialty in the granting jurisdiction.

12. Medical Readiness Training Certification. A process that verifies the preparation of healthcare providers for operational requirements. The commander's review and verification of individual, collective, and unit medical readiness training, education, and experiences is a critical element of the process.

13. Military Health Services System (MHSS). The combination of military and civilian medical systems used to provide healthcare to DoD medical beneficiaries.

14. National Practitioner Data Bank (NPDB). The agency designed by the Department of Health and Human Services to receive and provide data on substandard clinical performance and conduct of physicians, dentists, and other licensed healthcare practitioners, including data on malpractice claims payment made on behalf of those practitioners.

15. Network. The combination of the MTF and other civilian preferred providers (e.g., individuals, groups, hospitals, and clinics) who have agreed to accept DoD and Uniformed Services beneficiaries enrolled in the regional managed care program authorized by the ASD (HA). Networks' providers deliver healthcare at negotiated rates, adhere to provider agreements, and follow other requirements of the managed care program. Civilian network healthcare providers are independent contractors of the Government (or other independent entities having business arrangements with the Government). Each civilian network provider must have adequate professional liability insurance and must agree to indemnify the United States Government for any liability that may be assessed against the United States Government that is attributable to any action or omission of the provider.

16. Other Authorizing Document

a. A mechanism, such as registration and certification, by which a State; the District of Columbia; or a Commonwealth, territory, or possession of the United States grants authority to provide healthcare in a specified discipline; or,

b. In specialties not licensed and where the requirements of the granting authority for registration or certification are highly variable, the validation by a national organization that a practitioner is professionally qualified to provide healthcare in a specified discipline; or

c. In the case where healthcare is provided in a foreign country by any person who is not a national of the United States, a grant of permission by an official agency of that foreign country for that person to provide healthcare in a specified discipline.

17. Privileges (clinical). Permission to provide medical and other patient care services in the granting institution, within defined limits, based on the individual's education, professional license, experience, competence, ability, health, and judgment.

18. Professional Staff Appointment. A process whereby formal, written authorization to perform patient care is accompanied by a delineation of authorized clinical privileges and a pledge to abide by the rules and regulations of the medical or dental staff.

a. Active Staff Appointment. Staff appointments granted to providers, according to the needs of the government, who successfully complete the initial staff appointment period.

b. Initial Staff Appointment. The initial professional staff appointment granted to the provider for a period not to exceed 12 months to demonstrate current clinical competence and compliance with the facility's policies, procedures, and bylaws.

19. Professional Impairment. A healthcare practitioner characteristic that may adversely affect the ability to render quality care. Professional impairment may include deficits in medical knowledge, expertise, or judgment; unprofessional, unethical, or criminal conduct; and any medical condition that reduces or prevents the practitioner's ability to safely execute his or her responsibilities in providing healthcare.

20. Supervision. The process of reviewing, observing, and accepting responsibility for assigned personnel.

a. Indirect. The supervisor performs retrospective record review of selected records. Criteria used for review relate to quality of care, quality of documentation, and the authorized scope of practice.

b. Direct. The supervisor is involved in the decision-making process. This may be further subdivided as follows:

(1) Verbal. The supervisor is contacted by phone or informal consultation before implementing or changing a regimen of care.

(2) Physically Present. The supervisor is present physically through all or a portion of care.

PRESELECTION CRITERIA FOR HEALTHCARE PRACTITIONERS

Evidence of the criteria listed in this enclosure, below, must be verified through the primary source and documented. Unless specified, secondary sources are supplementary and do not meet the requirement.

- A. Qualifying educational degree(s).
- B. Postgraduate training and fellowship for requested clinical privileges and/or scope of practice.
- C. State licenses, registration, certification, or other authorizing document. (A list of all healthcare licenses held in the last 10 years shall be provided and an explanation of any licenses that are not current, have been voluntarily relinquished, or have been subjected to disciplinary action shall be attached.)
- D. A current report from the NPDB for all physician and dentist providers.
- E. Specialty board status, if applicable. (Board certification in medical board specialties shall be verified either through the primary source (the issuing body) or through the secondary source as described in the "Accreditation Manual for Hospitals" (reference (f)).
- F. Chronological practice experience to account for all periods of time after graduation.
- G. A statement of the applicant's ability to perform his or her professional activities and proof of current professional competence (letters of recommendation from the program or training director and a recent description of scope or practice and/or clinical privileges by the directors of the facility in which the applicant currently is practicing) as described in reference (f).
- H. Documentation of any medical malpractice claims, settlements, or judicial or administrative adjudication with a brief description of the facts of each case listed.
- I. Any history of adverse clinical privilege and/or disciplinary action by a hospital, State licensure board, or other civilian Government Agency. This shall include voluntary or involuntary termination of professional and/or medical staff membership or voluntary or involuntary suspension, limitation, restriction, or revocation of clinical privileges at a hospital or other healthcare delivery setting, and any resolved or open charges of misconduct, unethical practice, or substandard care.
- J. A statement of the applicant's health status, about his or her ability to provide healthcare. The statement must be confirmed as described in reference (f).
- K. Peer interview summary. Non-board certified physicians who allege to be specialists shall have two letters attesting their clinical competence by physicians certified in the specialty in which the non-board certified physicians are practicing. Those physicians who have not

completed their initial period of qualification for board certification shall have two letters attesting their clinical competence from board-certified specialists who have current knowledge of their clinical practice.

L. Drug Enforcement Agency certificate (where applicable).

M. Federal Bureau of Investigation background check and State criminal history repository checks, in accordance with DoD Instruction 1402.5 (reference (p)).

N. A signed statement consenting to the inspection of records and documents pertinent to consideration of his or her request for accession or employment.

O. A signed statement attesting to the accuracy of all information provided.

REPORTABLE ACTIONS OF MISCONDUCT FOR DoD HEALTHCARE
PRACTITIONERS

The following misconduct actions shall be reported, at the times prescribed, to the Surgeons General, the Federation of State Medical Boards, and the appropriate State agencies under DoD Directive 6025.14 (reference (m)). (Each of the actions listed shall be cause for initiation of processing for separation for cause or for adverse personnel action under applicable Service regulations. Nothing in this Directive limits the lawful prerogatives of commanders to discipline the members of their command, nor does anything in this Directive limit the lawful prerogatives of civilian authorities to enforce the criminal and civil laws of their jurisdictions.)

A. Misconduct Actions to be Reported After Command Action and Completion of
Applicable Appeal Procedures

1. Fraud or misrepresentation involving application for enlistment, commission, employment, or affiliation with DoD service that results in removal from service;
2. Fraud or misrepresentation involving renewal of contract for professional employment, renewal of clinical privileges, or extension of Service obligation;
3. Proof of cheating on a professional qualifying examination; and
4. Abrogation of professional responsibility through any of the following actions:
 - a. Deliberately making a false or misleading statement to patients as regards clinical skills or clinical privileges;
 - b. Willfully or negligently violating the confidentiality between practitioner and patient except as required by civilian or military law;
 - c. Being found impaired by reason of drug abuse, alcohol abuse, or alcoholism;
 - d. Intentionally aiding or abetting the practice of medicine or dentistry by obviously incompetent or impaired persons;
 - e. Commission of an act of sexual abuse or exploitation related to clinical activities, or non clinically related indications of sexual misconduct, such as promiscuity, bizarre sexual conduct, indecent exposure, rape, contributing to the delinquency of a minor, or child molestation, when, in the commander's judgment, such activities impair the practitioner's overall effectiveness and credibility within the healthcare system, or within his or her professional or patient communities;
 - f. Prescribing, selling, administering, or providing controlled substances as defined by 21 U.S.C. 801-977 (reference (q)) for use by the practitioner or a family member of the

practitioner without written approval of the Medical Commander, or admitted misuse of such substances by the practitioner;

g. Failure to report to the privileging authority any disciplinary action taken by professional or governmental organizations;

h. Failure to report to the privileging authority any malpractice awards, judgments, or settlements occurring outside of DoD facilities;

i. Failure to report to the privileging authority any professional sanction taken by a civilian licensing agency or healthcare facility;

j. Any violation of the Uniform Code of Military Justice (reference (e)) for which the member was awarded non judicial punishment when the offense is related to a practitioner's ability to practice his or her profession or which impairs the practitioner's credibility within the healthcare system or within his or her professional community; and,

k. Commission of any offense that is punishable in a civilian court of competent jurisdiction by a fine of more than \$1000 or confinement for over 30 days, for offenses related to professional practice or which impair the practitioner's credibility within the healthcare system or within his or her professional community.

B. Administrative Discharge. Discharge instead of court-martial or administrative discharge while charged with an offense designated in this enclosure after command action and completion of applicable appeal procedures.

C. Misconduct to be Reported Upon Referral for Trial by Courts-Martial or Indictment in a Civilian Court and Upon Final Verdict, Adjudication, or Administrative Disposition

1. Offenses punishable by a fine of more than \$5000 or confinement in excess of 1 year by the civilian jurisdiction in which the alleged offense occurred;

2. Offenses punishable by confinement or imprisonment for more than 1 year under 10 U.S.C 801-940 (reference (e));

3. Entry of a guilty or nolo contendere plea, or request for discharge instead of court-martial while charged with an offense designated in subsection C.1. or 2., above;

4. Committing an act of sexual abuse or exploitation in the practice of medicine, dentistry, nursing, or other professional practice of healthcare as may be designated by the ASD(HA);

5. Inappropriately receiving compensation for treatment of patients eligible for care in DoD hospitals; and,

6. Possessing or using any drug legally classified as a controlled substance for other than acceptable therapeutic purposes.